MEDICAL CERTIFICATE
Form P-33B—Caregiver (Revised 06/00)
(To be used by employee seeking family leave to care for a spouse, child, or parent with a "serious health condition"/"serious illness.")

State of Connecticut
Department of Children and Families
Human Resources
505 Hudson Street, Hartford, CT 06106
Must be submitted within 30 days of foreseeable leave.

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AGENCY INSTRUCTIONS

This medical certificate is to be used by employees seeking family leave to care for a spouse, child, or parent with a "serious health condition"/"serious illness." It shall be given to the employee or sent directly to the physician or practitioner of the child, spouse or parent who needs care. The name of the person and the address of the agency to which this certificate is to be returned shall be inserted in the space provided. The PHYSICIAN OR PRACTITIONER will generally return the filled out certificate to the agency head or authorized representative. Fill in below the employee's name, position, and address, and the name of the patient and his/her relationship to employee.

AGENCY FILL IN

AGENCY HEAD OR REPRESENTATIVE | AGENCY NAME

AGENCY ADDRESS (*No. and Street*) | *(City or Town)* | *(State)* | *(ZIP Code)*

EMPLOYEE'S NAME

EMPLOYEE'S POSITION | DEPARTMENT

ADDRESS (*No. and Street*) | *(City or Town)* | *(State)* | *(ZIP Code)*

PATIENT'S NAME | RELATIONSHIP TO EMPLOYEE

CONDITIONS GOVERNING ISSUANCE

No federal FMLA, state family leave (C.G.S. 5-248a), special leave with pay in excess of five (5) days, or leave as otherwise prescribed by contract, shall be granted state employees unless supported by a medical certificate filed with, and acceptable to, the appointing authority. The period of employee absence must be reported with a description of the nature of the patient's incapacity entered under Section (2) and/or Section (7) below.

TO BE FILLED IN BY ATTENDING PHYSICIAN OR PRACTITIONER

(Please print legibly.)

This form must be executed by a physician or practitioner whose method of healing is recognized by the State, except where otherwise indicated.

(1) Pages 3-4 of this form describe what is meant by a **"serious health condition"/"serious illness"** under federal FMLA and state family/medical leave (C.G.S. 5-248a). Does the patient's condition qualify under any of the categories described? *(Please be sure to refer to pp. 3 and 4 for specific definitions.)* _____
(fill in "yes" or "no")

If yes, please check the appropriate category:

_____ Hospital Care
_____ Absence plus treatment
_____ Pregnancy
_____ Chronic conditions requiring treatments
_____ Permanent/long-term conditions requiring supervision
_____ Multiple treatments (non-chronic conditions)
_____ None of the above

(2) If this is for an FMLA qualifying reason, describe the medical facts that support your certification, including a brief statement as to how the medical facts meet the criteria of one of the categories on pages 3-4. If this is not for an FMLA qualifying reason, describe the medical facts that support your certification of the patient's medical condition. If additional space is needed, continue remarks under Section (7) of this form.

_____

_____

_____

(3) (a) Answer the following:

1. The approximate **date** the condition commenced. _____
2. The probable **duration** of the condition. _____
3. The probable duration of the patient's present **incapacity** (if different from (3)(a) 2. above). _____
4. The date of the patient's most recent examination_____

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TO BE FILLED IN BY ATTENDING PHYSICIAN OR PRACTITIONER
(Please print legibly.)

(b) If condition is a **"chronic condition"** (as checked off under Section (1)), state whether the patient is presently incapacitated and the likely duration and frequency of episodes of incapacity:
_____ Patient _____ *is* _____*is not* presently incapacitated. *(check one)*
_____ **duration** of episodes of incapacity = _____ *(hours or days, etc.)*
_____ **frequency** of episodes of incapacity = _____ *(no. of times per week or month, etc.)*

(4) (a) If **additional treatments** will be required for the condition, provide:
_____ an estimate of the probable **number** of such treatments. _____

_____ an estimate of the probable **interval between** such treatments. _____

_____ actual or estimated **dates** of treatment, if known. _____

_____ period required for **recovery**, if any. _____

(b) If any of these treatments will be provided by **another provider of health services** (e.g., physical therapist), please state the nature of the treatment and period of time covered.
_____

_____

(c) If a regimen of continuing treatment by the patient is required under your supervision, provide a general description of such regiment (e.g., prescription drugs, physical therapy requiring special equipment).
_____

_____

(5) (a) Does the patient **require assistance** for basic medical or personal needs or safety, or for transportation? _____
(fill in "yes" or "no")

(b) If no, would the employee's presence to provide **psychological comfort** be beneficial to the patient or assist in the patient's recovery? _____
(fill in "yes" or "no")

(c) If the patient will need care only **intermittently** or on a **part-time basis**, please indicate the probable duration and frequency of this need.
_____

_____

(6) The caregiver/employee will be able to return to work on _____ *(date).*

(7) Additional remarks:
_____

_____

_____

_____

NAME OF PHYSICIAN OR PRACTITIONER (please type or print)			
ADDRESS (*No. and Street*) *(City or Town)* *(State)* *(ZIP Code)*			
SIGNED (Physician or Practitioner)	DATE	TELEPHONE	

FEDERAL FMLA:

Under the federal FMLA, **"Serious Health Condition"** is defined as an illness, injury, impairment, or physical or mental condition that involves:

- Any period of incapacity or treatment related to inpatient care (i.e., an overnight stay in a hospital, hospice, residential facility), **OR**
- Continuing treatment by a health care provider.

"Continuing treatment" by a health care provider includes any one or more of the following:

1) Absence Plus Treatment: A period of incapacity of more than three consecutive calendar days and any subsequent treatment or period of incapacity relating to the same condition, that also involves:
   - Treatment two or more times by a health care provider, by a nurse or physician's assistant under direct supervision of a health care provider, or by a provider of health care services (e.g. physical therapist) under orders of, or on referral by, a health care provider, **OR**
   - Treatment by a health care provider on at least one occasion which results in a regimen of continuing treatment under the supervision of the health care provider.

2) Pregnancy: Any period of incapacity due to pregnancy, or for prenatal care.

3) Chronic Conditions Requiring Treatments: Any period of incapacity or treatment for such incapacity due to a chronic condition which:
   - •Requires periodic visits for treatment by a health care provider or by a nurse or physician's assistant under direct supervision of health care provider;
   - •Continues over an extended period of time (including recurring episodes of a single underlying condition); **AND**
   - •May cause episodic rather than a continuing period of incapacity. **Examples:** *asthma, diabetes, epilepsy.*

4) Permanent/Long-term Conditions: A period of incapacity which is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. **Examples:** *Alzheimer's, a severe stroke, or the terminal stages of a disease.*

5) Multiple Treatments (Non-Chronic Conditions): Any period of absence to receive multiple treatments (including any period of recovery therefrom) by a health care provider or by a provider of health care services under orders of, or on referral by, a health care provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment. **Examples:** *cancer (chemotherapy, radiation, etc.), severe arthritis (physical therapy), and kidney disease (dialysis).*

Note: Substance abuse may be a serious health condition if the conditions mentioned above are met. However, FMLA leave may only be taken for *treatment* for substance abuse by a health care provider or by a provider of health care services on referral by a health care provider. On the other hand, absence *because of* the employee's use of the substance, rather than for treatment, does **not** qualify for FMLA leave.

Please Note: For the purposes of federal FMLA the following terms are defined to mean:

- **"Incapacity"** – inability to work, attend school or perform other regular daily activities due to the serious health condition, treatment therefor, or recovery therefrom.

- **"Treatment"** – includes examinations to determine if a serious health condition exists and evaluations of the condition. It does not include routine physical examinations, eye examinations, or dental examinations.

- A **"regime of continuing treatment"** – includes, for example, a course of prescription medication (e.g. an antibiotic) or therapy requiring special equipment to resolve or alleviate the health condition. It does not include the taking of over-the-counter medications such as aspirin, antihistamines, or salves, or bed-rest, drinking fluids, exercise, and other similar activities that can be initiated without a visit to a health care provider.

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STATE FAMILY/MEDICAL LEAVE (C.G.S. 5-248a):

Under the state's family/medical leave law, **"Serious Illness"** is defined as an illness, injury, impairment or physical or mental condition that involves:

- Inpatient care in a hospital, hospice, or residential care facility;

  OR

- Continuing treatment or continuing supervision by a health care provider [C.G.S. 5-248a(c) and CT State Regulation 5-248b-1(d)].